Mental Health Series

Secondary Traumatic Stress in Mental Health Professionals

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INTRODUCTION

Over the last decade, citizens of the United States have increasingly been the targets of mass violence, terrorism, criminal acts and natural disasters.[1] Mental health professionals specializing in these areas who are called to treat victims of this trauma, "hear tales of extreme human suffering and observe the emotions of fear, helplessness and horror registered by survivors on a consistent basis. Recent research has shown these occupational roles may cause psychological symptoms in the professional witnesses to the victims' report of this trauma.[2] As a result, mental health professionals, like other responder groups, risk becoming secondary victims of the traumatic events.[1]

DEFINING THE ISSUES

The effect of traumatic events on mental health professionals has been referred to as Secondary Traumatic Stress (STS) and includes Compassion Fatigue and Vicarious Traumatization. STS is considered an under-studied and controversial clinical phenomenon. It is conceptualized as a reaction to the emotional demands on these professionals and from exposure to trauma survivors who experienced terrifying, horrifying, and intrusive traumatic memories.3

Compassion Fatigue and Vicarious Traumatization focus on negative experiences with a few differences. Compassion Fatigue is symptom based. It is considered a state of exhaustion with impaired functioning. The specific symptoms reflect a reexperiencing of the traumatic event, avoidance/numbing, and continued arousal similar to those individuals who suffer from PTSD. Vicarious Traumatization may also include symptoms found with PTSD but differs from Compassion Fatigue due to a lack of focus on observable symptoms. Vicarious Traumatization may not include overt symptomatology or impaired functioning, but the professional may experience basic and far reaching changes in the way he views himself and the world, including alterations in his beliefs about trust, safety, control, attachment and esteem for others. These changes can take an enormous toll on the professional's life as a whole.[4]

Studies predicting STS have reached contradictory conclusions about the correlates of STS. However, factors thought to predict a mental health professional developing STS include the professional's personal trauma history, inadequate training, identification with the victims, insufficient support in the workplace and insufficient social and familial support.2

As with trauma survivors, assessment hinges on the question of "How much normal stress reaction is too much?" Each professional will have his or her own pattern of stress response.[1] Three self-report inventories have been used to measure STS. They include the Compassion Fatigue Self-Test (CFST), the TSI Belief Scale (TSI-BLS) and the Secondary Trauma Questionnaire (STQ). The CFST and STQ items closely measured trauma exposure and PTSD symptomatology found with Compassion Fatigue. The TSI-BLS measures changes in the schemas of safety, trust, esteem, intimacy and control consistent with Vicarious Traumatization. Standardized clinical interview specific to secondary traumatization have not been developed.[2]

PREPARING FOR PREVENTION

In spite of conflicting data, there is enough evidence of STS to know that it can be an occupational hazard for mental health professionals. Recognizing this, there is an obligation to prepare professionals for these possibilities.[5] Prevention is key and includes interventions before and after the professional's involvement. Some studies show regular consultation while working with victims or survivors to process the painful client material, personal emotions, or cognition is important in preventing STS.[5] Other studies have indicated four domains as an important part of prevention when working with individuals. These domains are: professional strategies (balancing caseloads); organization strategies (sufficient release time); personal strategies (respecting one's own limits)' and general coping strategies (self nurturing).[2] However, prevention techniques should always include adequate training. Training may be offered soon after an incident to assist mental health professionals who immediately respond, or incorporated into their training program prior to an event. Each incident is unique, therefore, trainers will need to recognize the differences.[1]

CONCLUSION

The impact of terrorism, natural disasters or criminal acts is widespread and, to varying degrees, affects victims, responders and the community at large. Studies indicate that mental health professionals involved in the treatment of these victims can suffer from STS. Although further studies of this

phenomenon are needed, prevention of STS is key. Prevention should include consulting and training of professionals as well as the professional maintaining of an adequate balance in their life. ■

References

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